Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Centre name:	Marymount University Hospital & Hospice
Centre ID:	ORG-0000582
Centre address:	Curraheen Road, Curraheen, Cork.
Telephone number:	021 450 1201
Email address:	info@marymount.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	St Patrick's Hospital (Cork) Limited
Provider Nominee:	Dan Philpott
Person in charge:	Sarah McCloskey
Lead inspector:	Breeda Desmond
Support inspector(s):	Gemma O'Flynn
Type of inspection	Announced
Number of residents on the date of inspection:	63
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 May 2014 09:30	19 May 2014 18:30
20 May 2014 08:00	20 May 2014 15:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Statement of Purpose
Outcome 02: Contract for the Provision of Services
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 05: Absence of the person in charge
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 09: Notification of Incidents
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents Rights, Dignity and Consultation
Outcome 17: Residents clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection and it was the eight inspection undertaken by the Authority in this centre. The provider applied to renew their registration which will expire on 10 September 2014. This renewal of registration inspection took place over two days. As part of the inspection the inspectors met with the person in charge, newly appointed designated provider, and the recently appointed acting assistant director of nursing (ADON), residents, relatives, and staff members. The inspectors observed practices and reviewed all governance, clinical and operational documentation to inform this registration application.

The provider and person in charge displayed knowledge of the standards and regulatory requirements and were found to be committed to providing quality person-centred evidence-based care for the residents.

Twenty questionnaires were received and the inspector spoke with many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged and this was observed throughout the inspection.

All staff had received training in elder abuse prevention and protection to safeguard residents in their care. Staff levels and skill-mix appeared adequate to meet the assessed needs of residents. Residents were encouraged to exercise choice and their views were sought informally on a daily basis and formally in the residents' committee, which were held monthly.

The physical environment was comfortable and bright with external secure gardens.

There were many issues identified relating to fire safety precautions that warranted an immediate action plan which included:

1) staff training
2) fire safety evacuation notices were not displayed in a prominent position or in an accessible format
3) daily fire checks not completed
4) external fire hydrants not easily identifiable
5) some fire doors did not have appropriate mechanisms to ensure their correct operation.

The inspectors identified other aspects of the service requiring improvement to enhance the findings of good practice on this inspection which will be outlined in the body of the report.

The action plan at the end of this report sets out the actions necessary to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The statement of purpose was reviewed and updated in May 2014 to reflect the recent changes to the management structure and the name of the centre. Services and facilities were described accurately. All items listed in Schedule 1 of the Regulations were detailed in the statement of purpose and was reviewed annually.

Judgement:
Compliant

Outcome 02: Contract for the Provision of Services

Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Contracts of care were maintained by administration staff. The contracts detailed fees to be charged as well as additional fees. Samples of contracts of care for residents were examined. Those examined by the inspectors were signed and dated by either the resident or their next of kin in line with regulatory requirements.

Judgement:
Compliant

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The post of the person in charge was full time and held by a registered nurse with the required experience of nursing dependant people. She was the director of nursing for both the residential care setting and palliative care unit. She demonstrated knowledge and understanding of the Regulations and National Standards to ensure suitable and safe care. Clear management and accountability structures were in place. The person in charge was engaged in governance, operational management and administration associated with her role and responsibilities. There was evidence that the PIC had a commitment to her own continued professional development and had completed many courses such as Masters of Science degree, diploma in Leadership and Quality in Healthcare, and currently undertaking a Clinical Doctorate in Nursing.

The person in charge was supported in her role for older persons' services by the recently appointed assistant director of nursing (ADON). The ADON for palliative care, was also involved in the management of the designated centre.

Judgement:
Compliant

Outcome 04: Records and documentation to be kept at a designated centre
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspectors was satisfied that the records required in Schedule 2 (staff files),

Schedule 3 (residents' records) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. However, at the time of inspection many of the policies relating to Schedule 5 (operating policies and procedures) required attention as their review date was five years rather than three years and many others were out-of-date. Schedule 4 (general records) which included maintenance of residents' finances were not adequately maintained and this will be discussed under Outcome 6; the complaints policy and procedure required attention and will be discussed under Outcome 13. A daily record of nursing care as described in the Regulations, was not maintained in line with best practice in documents included in Regulation 25 (medical records). Contact details of access to the Chief Inspector were not included in the residents' guide in compliance with Regulation 21. The register of residents was reviewed and it contained all of the information required by legislation. Overall records were seen to be stored in line with best practice and legislative requirements. The person in charge relayed to inspectors that all policies and procedures were being updated at the time of inspection.

Judgement:
Non Compliant - Moderate

Outcome 05: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The PIC was aware of her responsibilities relating to Regulation 37 and 38 regarding notification to the Authority should the occasion arise. Appropriate deputising arrangements were in place to ensure care and welfare of residents. The recently appointed ADON had direct responsibility for the designated centre and the ADON for palliative care assumed responsibility for the designated centre when necessary. Clinical nurse mangers were in place on each unit with responsibility for the day-to-day running of their unit. The inspector interviewed the recently appointed ADON who demonstrated a good awareness of her regulatory responsibilities as well as clinical knowledge.

Judgement:
Compliant

Outcome 06: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

Theme:
Safe Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Measures were in place to protect residents from being harmed or suffering abuse. The training matrix detailed completed training for staff as well as alerts for those whose training was due to expire. Staff spoken with demonstrated their knowledge of protection of residents in their care and actions to be taken if they had a concern about the standard of care.

The provider and person in charge were continually in the centre. The CNMs spoke with residents on a daily basis and with relatives also and supervised staff as part of ensuring the safety of residents. Feedback from residents was positive and many stated they felt 'safe, secure, and very content' in the centre. Relatives' questionnaires stated that the utmost respect was shown to their relative; they were welcome to visit anytime, and that great attention was given to their relatives' needs regarding health and comfort.

Photographic identification is required for each resident as part of safe medication management, unexplained absence of a resident and other legislative requirements. Consent for such photographs was obtained from residents.

While there was an up-to-date policy for adult protection, it did not contain the information as stipulated in Regulation 36 regarding immediate notification to the Authority of an allegation of abuse.

Residents' finances were examined and these were not maintained in line with best practice. Transactions logs for credit and debit transactions were not in place. Dual signatures with either the resident and staff or two staff members were not evidenced for transactions viewed. Cash returned was undated with no signature in place and the balance was incorrect. In summary, a system to safeguard residents' money was not in evidence.

Judgement:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe Care and Support

Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The new health, safety and risk management policy contained comprehensive details on the identification and prevention of risks in conjunction with the recording and investigation from serious incidents or adverse events. The emergency plan was available with alternative accommodation detailed, should the need arise. As part of the continuous monitoring of safety of services, there was a risk management committee established which convened monthly and minutes from these meetings were available. Standard items on the agenda included medication errors and near misses, infection prevention and control, incidents/accidents as well as other risks identified. Follow-up of issues were evidenced in these minutes. While management described to the inspectors weekly health and safety audits of the environment undertaken, this was not formalised.

There was a current policy in place for infection prevention and control. Advisory signage for best practice hand washing was displayed over hand-wash sinks. There were hand hygiene gel dispensers available throughout the centre. Advisory signage for best practice use of hand hygiene gels was displayed and the inspectors observed that opportunities for hand hygiene were taken by staff. Staff, including cleaning staff, had completed training in hand hygiene and infection prevention and control. Cleaning staff spoken with demonstrated excellent knowledge of infection prevention and control responsibilities and practices. The designated areas for storage of chemicals were secure to prevent unauthorised access.

Current relevant fire certification for maintenance and servicing was reviewed. While a fire safety register was in place, with weekly and monthly fire safety checks evidenced, daily fire safety checks were not completed in line with best practice guidelines. Staff had not completed their mandatory fire training. Fire drills were completed six-monthly and this was evidenced by fire training records reviewed, however, it was difficult to determine if all staff had completed this training. Fire safety evacuation notices were not displayed in a prominent position or in an accessible format for residents. A recent fire officers' report demonstrated that external fire hydrants were not adequately identified and this remained unresolved. Some internal fire doors did not have the appropriate mechanism to ensure their correct function and operation. Fire doors were kept ajar with door wedges and chairs, nullifying their effectiveness.

All staff had completed their mandatory training in moving and handling of residents.

A current insurance policy was available.

A record was maintained of incidents and accidents with associated investigations and learnings identified. These were reviewed every fortnight by the risk management committee. In June 2013, the committee commenced a quality improvement initiative in the form of a newsletter called 'risky business', to inform staff of issues identified and guidance on preventing similar problems in the future. These were a two-monthly publication and in a format that was precise and easy to follow.

Laundry was segregated at source and staff described best practice regarding safe handling of unclean laundry with the use of alginate bags were appropriate.

Judgement:
Non Compliant - Major

Outcome 08: Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Safe Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The centre-specific medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines was being updated. Nursing staff with whom the inspector spoke demonstrated best practice regarding administration of medicines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines. Medication trolleys were securely maintained within the secure nurses' station. Medication fridges were in place in each unit and while temperatures were recorded on alternate days (Monday, Wednesday, and Friday) they were not recorded the other four days in line with best practice guidelines.

A sample of prescriptions were reviewed and while they were largely in compliance with professional guidelines, the maximum dosage was not included in those reviewed. While the medication audit was extensive it did not contain this detail to ensure compliance with professional guidelines. Medication management audits were completed by the senior pharmacist and these were evidenced during inspection. Issues identified from these audits were brought to the risk management committee with feedback to all relevant staff. There was documentary evidence of this. The staff reported to the inspector that the pharmacist was easily accessible regarding advice relating to drug interactions, dosages, and crushing of medicines.

The procedure for returning unused or out-of-date medications was not robust and required attention as returned medications were not signed for by the recipient or the staff member returning medications. This safeguard was in place for return of controlled drugs.

Judgement:
Non Compliant - Minor

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Notifications received by the Authority were reviewed upon submission and prior to the inspection. Notifiable incidents and quarterly returns submitted to the Authority were timely and comprehensive. A record was maintained of incidents occurring in the centre and these correlated with residents' care plans.

Judgement:
Compliant

Outcome 10: Reviewing and improving the quality and safety of care
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:
Effective Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Residents and relatives spoken with gave positive feedback regarding communication and involvement with their relative's care and welfare and the ease of access to staff to discuss matters.

The inspector spoke with the CNM with responsibility for activities who outlined an extensive programme and residents spoken with concurred that there was a range of activities available if they chose to attend. Some residents reported that they attended religious service every other day and had access to it on their bedside television, which also contained radio, telephone and computer facilities. Inspectors visited residents in the physiotherapy gym. Following their exercise class residents, volunteers and staff sit around and discuss articles from the daily newspaper and residents appeared to enjoy this session.

While audits were completed, a formal structure to ensure systems and processes were in place to effectively manage and implement an integrated programme of quality and safety was not embedded. Infection prevention and control, the quality group, health

and safety committee met regularly and reported into the quality assurance, risk management and audit committee who in turn report into the Board of Directors. Meetings were convened two-monthly and minutes from these meetings were evidenced. Where actions were identified with responsibilities assigned, integration to prevent duplication or omissions was not evident in that some audits did not make any recommendations to improve quality and safety, or, where there were recommendations, these were not implemented.

Judgement:
Non Compliant - Moderate

Outcome 11: Health and Social Care Needs
Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective Care and Support

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
A sample of residents' assessments and care plans were reviewed by inspectors on each unit. It was identified on previous inspections that care plans were not person-centred and while there was a little personal information documented, overall care plans remained generic with very little information to guide and direct staff to meet individuals' needs or wishes. Nonetheless, staff spoken with had an in-depth knowledge of individual residents in their care. The 'Life Story' and 'A Key to Me' were in place for each resident, however, of the sample viewed, they were not written in the 'first' person but rather the 'third person'. While there was some evidence that relatives were involved in aspects of care planning, overall there was no documented evidence that care plans had been developed and agreed with the resident and/or their representative as described in the Regulations.

A sample of documentation was reviewed for residents admitted for respite care. While risk assessments were in place for respite residents, there were no care plans to inform care.

The medical director was available five days a week with appropriate out-of-hours cover when necessary. A sample of medical records reviewed demonstrated that residents were reviewed on a regular basis. Specialist medical services were also available when

required. Reviews and on-going medical interventions as well as laboratory results were evidenced.

There was a dedicated physiotherapist for the centre as well as a well equipped physiotherapy department. Residents were assessed by the physiotherapist and an activities programme developed tailored to individual needs. Other specialist services available to residents included podiatry, occupational therapy, speech and language therapy and dietician were available upon referral. Optical services were facilitated in-house and dental services were available externally.

Judgement:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Care and Support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Marymount is a three-storey, purpose-built centre and is part of a large hospital building that includes palliative care, an education centre and offices. All floors were accessible by a number of lifts and stairs. The designated centre for older people comprised three 21-bedded wards/units, St Anne's Ward on the lower ground floor, St John's Ward on the ground floor, and St Camillus' Ward on the first floor. The palliative care services were in a separate block with some shared clinical facilities for both services on the ground floor including physiotherapy, hairdressing, podiatry, medical consultation rooms and treatment rooms.

The continuing care wards each contain 17 single bedrooms with en suite facilities of toilet, wash-hand basin and shower. Two of these single rooms were isolation rooms and two were bariatric rooms with larger beds accommodating residents with increased body mass index. There was one four-bedded room on each ward with two full en suite facilities to accommodate respite residents. In addition to en suite facilities there was a large assisted bathroom with jacuzzi bath and a number of assisted toilets. Communal accommodation comprised a combined day and dining room and a second sitting room. Residents who smoke were facilitated to use the covered-in communal balcony areas. At the entrance to each ward there was a reception area and nurses' station and bedroom areas were accommodated along two corridors from the nurses' station.

There was an activity department away from the ward areas with dining, sitting and

therapy areas. Other communal areas provided for residents use included a central large modern oratory for use by all of the services and an additional prayer room. Overnight accommodation was provided for relatives if the need arose. Occasional seating areas were located throughout.

There were large secure gardens which were easily accessible from the wards and activities area which contained ample seating for the residents. There were walkways around the building and seating for residents and relatives to enjoy the view of the countryside.

Large car parks were available to the front and side of the building.

Judgement:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The complaints procedure was displayed however, it was not displayed prominently as required in the Regulations. Also, the procedure was difficult to follow and not in an accessible format suitable for residents. It did not contain all the items as listed in the Regulations. While some complaints were recorded, all issues brought to the attention of staff were not recorded to facilitate learning. The complaints log was reviewed and while they were recorded in line with the Regulations, whether the complainant was satisfied with the outcome, was not documented. The CNMs on each unit monitored complaints and endeavoured to resolve issues as soon as they arose. Documented complaints were submitted to administration where they were followed up and monitored by the quality committee.

Judgement:
Non Compliant - Minor

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
There was a policy in place for end-of-life care and this was in date.

Spiritual needs were facilitated and religious service held in the centre every other day and Sunday with all denominations being facilitated upon request; there was a team of pastoral care personnel available for all residents. Residents had access to consultant palliative care and the hospice services. Staff had completed professional development regarding end of life care, palliative care and specialist syringe-driver. Care practices observed would suggest that residents would be cared for with the utmost respect.

Judgement:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was a policy in place for risk assessment, monitoring and documentation of nutritional status. Catering staff discussed nutritional needs including specialist diets with the inspector and demonstrated their knowledge regarding specialist diets and food consistency for residents. Staff had completed training in modified consistency food preparation. Residents had choice at each mealtime and residents spoken with gave positive feedback regarding the degree of choice as well as the quality of their food. Residents' weights were documented on a monthly basis or more often if their clinical condition warranted; dietary intake was recorded when necessary and residents were prescribed supplements when their condition necessitated. Residents had access to fresh water and other fluids throughout the day.

Previous inspections identified that the dining experience required attention as it was functional rather than a social occasion. Some improvements were observed in that most residents came to the dining room to dine rather than staying by their bedside and small vases of flowers brightened each dining table. Residents requiring assistance were helped appropriately and with respect. Lunch time was observed in the three units and

inspectors noted that tables were set as residents commenced their soup and not prior to commencement of their meal.

Judgement:
Non Compliant - Minor

Outcome 16: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The inspector reviewed minutes of the residents' advocacy meetings which were facilitated by the residents' advocate. This committee offered residents the opportunity to participate and engage in the running of the centre; residents made suggestions about meals, activities and voting.

The open visiting policy was observed throughout the inspection. Completed relatives questionnaires commended staff on how welcoming they were to all visitors. The manner in which residents were addressed by staff was seen by inspectors to be appropriate and respectful. However, privacy and dignity of some residents was compromised as residents' charts were hanging from door frames displaying personal information. Following review of one resident's notes, the inspector queried the rationale for decisions made and suggested that balancing risk while ensuring privacy and dignity required further review.

As described in Outcome 7 - Health and Safety and Risk Management, some fire doors required door wedges to keep them ajar as the mechanism to accommodate appropriate use was not in place. When door wedges were removed, these fire doors could not be maintained open and this greatly impeded residents' freedom, especially those with assistive devices.

Judgement:
Non Compliant - Minor

Outcome 17: Residents clothing and personal property and possessions
Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Locked storage space was provided for residents to store valuables as required. Residents' bedrooms were generally comfortable and some were personalised with residents' own cushions, bed throws, ornaments, and photos. Adequate space was provided to residents for storage of their clothing and belongings.

There was a policy on residents' personal property and possessions, however, this was out-of-date. A residents' property list (excluding clothing) was maintained in residents' documentation.

Many of the returned questionnaires completed by residents and relatives highlighted that laundry went missing. This was discussed with management who had themselves identified this as an issue. Laundry was externally sourced to two different laundries; one for residents' personal items and the second for bed linen. A route cause analysis identified that items were inappropriately segregated at source. This resulted in retraining of staff regarding the importance of appropriate segregation of laundry.

Judgement:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Workforce

Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Previous inspections identified significant issues regarding staff files. A sample of staff files were reviewed and those examined were complaint with the Regulations and contained all the items listed in Schedule 2.However, routine verification of references did not occur as described in the Regulations. This was discussed with the HR manager who outlined that written references were routinely sought for previous employers and

were in place for employees, however, while verification occurred it was not routine practice.The numbers and skill-mix of staff appeared adequate to meet the assessed needs of residents. Staff were supervised appropriate to their role and responsibilities.

Current registration with regulatory professional bodies was in place for all nurses. The staff training matrix examined demonstrated that manual handling and lifting and cardio-pulmonary resuscitation training was undertaken. Other staff training comprised end of life care, food safety, infection prevention and control, venepuncture, palliative care.

Staff appraisals were discussed. The person in charge relayed that appraisals had commenced for senior management and was in the process of being rolled-out for all staff.

Judgement:
Non Compliant - Minor

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Marymount University Hospital & Hospice
Centre ID:	ORG-0000582
Date of inspection:	19/05/2014
Date of response:	01/07/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Records and documentation to be kept at a designated centre

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The address and telephone number of the Chief Inspector was not included in the residents' guide.

Action Required:
Under Regulation 21 (1) you are required to: Produce a residents guide which includes a summary of the statement of purpose; the terms and conditions in respect of accommodation to be provided for residents; a standard form of contract for the provision of services and facilities to residents; the most recent inspection report; a summary of the complaints procedure provided for in Regulation 39; and the address and telephone number of the Chief Inspector.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take:
The resident's guide has been updated and the chief inspectors address and telephone number have been added to it.

Proposed Timescale: 13/06/2014

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A daily nursing record of the person's health and condition and treatment given was not maintained.

Action Required:
Under Regulation 25 (1) (b) you are required to: Complete, and maintain in a safe and accessible place, an adequate nursing record of each residents health and condition and treatment given, on a daily basis, signed and dated by the nurse on duty in accordance with any relevant professional guidelines.

Please state the actions you have taken or are planning to take:
A daily nursing record is maintained, but not in a narrative – this has now been amended.

Proposed Timescale: 13/06/2014

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All written operational policies and procedures of the designated centre were not reviewed at least every three years.

Action Required:
Under Regulation 27 (2) you are required to: Review all the written operational policies and procedures of the designated centre on the recommendation of the Chief Inspector and at least every three years.

Please state the actions you have taken or are planning to take:
All policies now have a 3 year review date.

Proposed Timescale: 13/06/2014

Outcome 06: Safeguarding and Safety

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A system to safeguard residents' money was not evidenced.

Action Required:
Under Regulation 6 (1) (a) you are required to: Put in place all reasonable measures to protect each resident from all forms of abuse.

Please state the actions you have taken or are planning to take:
There was an isolated incident that was uncovered during the inspection, which was outside of normal practices. The incident was investigated fully and relevant staff have been met regarding same. As a consequence of this, the following actions will be taken:
• A training schedule on the procedures to be followed for the safeguarding of residents monies will be devised by July.
• The training will be delivered by the end of September.
• A post-training competency task will form an integral part of the training.
• This will be completely delivered by November, and audited quarterly thereafter.

In the meantime there will be a reassignment of duties pertaining to residents finances to a memberof the Finance Department to ensure a high level of monitoring.

Proposed Timescale: 13/06/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was an up-to-date policy for adult protection, it did not contain the information as stipulated in Regulation 36 regarding immediate notification to the Authority of an allegation of abuse.

Action Required:
Under Regulation 6 (1) (b) you are required to: Put in place a policy on and procedures for the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
Notification to HIQA by PIC has now been added to policy on prevention, detection and response to abuse.

Proposed Timescale: 13/06/2014

Outcome 07: Health and Safety and Risk Management
Theme: Safe Care and Support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Procedures to be followed in the event of a fire were not prominently displayed in the designated centre. **Action Required:** Under Regulation 32 (3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre. **Please state the actions you have taken or are planning to take:** Fire procedures are now displayed on each wing of each ward with a clear map. In each residents room there is a fire evacuation notice.
Proposed Timescale: 22/05/2014
Theme: Safe Care and Support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Daily fire checks were not documented. **Action Required:** Under Regulation 32 (1) (c) (v) you are required to: Make adequate arrangements for reviewing fire precautions, and testing fire equipment, at suitable intervals. **Please state the actions you have taken or are planning to take:** Daily fire checks are now in place.
Proposed Timescale: 21/05/2014
Theme: Safe Care and Support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** External fire hydrants were not adequately identifiable for ease of access by fire personnel. **Action Required:** Under Regulation 32 (1) (c) (i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
External fire hydrants painted in aluminous paint.

Proposed Timescale: 22/05/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not completed annual training in fire safety and evacuation.

Action Required:
Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

Please state the actions you have taken or are planning to take:
10 sessions of fire training have been completed and a total of 160 out of 239 staff have attended. Further training sessions are planned in the next month for the remaining 79 staff.

Proposed Timescale: Plan to have all staff trained by September 2014.

Proposed Timescale: 27/05/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not completed bi-annual fire drills.

Action Required:
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

Please state the actions you have taken or are planning to take:
Fire drills will be held more frequently and exact names recorded.

Proposed Timescale: 27/05/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Many doors throughout the designated centre were held ajar with door wedges as well as chairs.

Action Required:
Under Regulation 32 (1) (c) (i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
These fire doors since the inspection are no longer held open as observed by HIQA. This is checked regularly by Marymount staff accordingly. Other resident doors without a fire door designation, will have their mechanical door closing mechanism deactivated. It is expected these door adjustments will be complete by the 15th July. This will allow appropriate doors to remain open if desired, by the particular patient/resident. This approach is approved by our Fire Officer and our other specialists in Fire Safety.

Proposed Timescale: 21/05/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The appropriate mechanism to ensure fire safety was not in place for all fire doors in the designated centre.

Action Required:
Under Regulation 32 (1) (c) (i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
Fire doors that did not have the mechanism for automatic closure are being fitted where relevant, e.g. 4 bedded rooms, sitting room and lower ground floor. See Action 6 for the remaining doors.

Proposed Timescale: 27/05/2014

Outcome 08: Medication Management

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Maximum dosage for PRN (as required) medications was not always documented in

residents' prescriptions to mitigate medication errors.

This safeguard did not form part of the medication audit checklist.

Action Required:
Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Please state the actions you have taken or are planning to take:
The drug chart needs to be revised and reprinted to allow for space to facilitate this request safely.

Proposed Timescale: 31/08/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedure for returning unused or out-of-date medications was not robust and required attention as returned medications were not signed for by the recipient or the staff member returning medications.

Action Required:
Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

Please state the actions you have taken or are planning to take:
Procedure now robust and well documented.

Proposed Timescale: 13/06/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An integrated system of reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre was not in place.

Action Required:

Under Regulation 35 (1) (a) you are required to: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

Please state the actions you have taken or are planning to take:
A schedule of audits will be drawn up.

Proposed Timescale: 31/08/2014

Theme:
Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some audits did not make any recommendations to improve quality and safety or where there were recommendations, these were not implemented.

Action Required:
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

Please state the actions you have taken or are planning to take:
An audit system will be put in place for the purpose of ensuring the quality and safety of patients. All audits will be reviewed by the Quality Group and the Quality, Risk Management & Audit committee to ensure that recommendations are being included and implemented accordingly. Action plans will be devised from audit findings. A schedule and database for audits and action plans will be available throughout the hospital. Audit findings will be circulated with recommendations; once recommendations are implemented the area of practice will be re-audited.

Proposed Timescale: 31/08/2014

Outcome 11: Health and Social Care Needs

Theme:
Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was identified on previous inspections that care plans were not person-centred and while there was a little personal information documented, overall care plans remained generic with very little information to guide and direct staff to meet individuals' needs or wishes.

Action Required:
Under Regulation 8 (1) you are required to: Set out each resident's needs in an

individual care plan developed and agreed with the resident.

Please state the actions you have taken or are planning to take:
a) Care plans to be reviewed and new system to be put in place.
b) Increase teaching on person centred planning.
c) Person centred working group.

Proposed Timescale:
a) Project to commence June 2014, with expected completion by Dec 2014.
b) Commenced.
c) Commenced.

Proposed Timescale: 31/12/2014

Theme:
Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Documentary evidence was not recorded to demonstrate that revision of care plans was completed in consultation with the resident and/or their next-of-kin.

Action Required:
Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

Please state the actions you have taken or are planning to take:
a) Care plans to be reviewed and new system to be put in place.
b) Increase teaching on person centred planning.
c) Will ask family members to sign where they have been involved.

Proposed Timescale:
a) Project to commence June 2014, with expected completion by Dec 2014.
b) Commenced.
c) Commenced.

Proposed Timescale: 31/12/2014

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was not displayed prominently.

Action Required:
Under Regulation 39 (4) you are required to: Display the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
Complaints procedure now displayed in ward reception areas and in sitting rooms, as opposed to general notice boards.

Proposed Timescale: 13/06/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While some complaints were documented, all issues brought to the attention of staff were not recorded.

Action Required:
Under Regulation 39 (9) you are required to: Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a residents individual care plan.

Please state the actions you have taken or are planning to take:
Meet with CNM's and staff to ensure that all complaints or issues brought to the attention of staff, be they formal or informal, are placed on the electronic complaints log and sent to the DoN for action.

Proposed Timescale: 30/06/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The outcome of whether the complainant was satisfied with the outcome, was not documented.

Action Required:
Under Regulation 39 (7) you are required to: Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The complaint template has been amended to reflect this.

Proposed Timescale: 13/06/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was difficult to follow and not in an accessible format suitable for residents.

Action Required:
Under Regulation 39 (1) you are required to: Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Please state the actions you have taken or are planning to take:
Complaints procedure now displayed in ward reception areas and in sitting rooms and now in an accessible format.

Proposed Timescale: 13/06/2014

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Lunch time was observed in the three units and inspectors noted that tables were set as residents commenced their soup and not prior to commencement of their meal.

Action Required:
Under Regulation 20 (2) part 3 you are required to: Provide each resident with food which is properly prepared, cooked and served.

Please state the actions you have taken or are planning to take:
Tables are set prior to mealtimes; there was 1 ward running late on the day of inspection.

Proposed Timescale: 13/06/2014

Outcome 16: Residents Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Privacy and dignity of some residents was compromised as residents' charts were hanging from door frames displaying personal information to passersby.

Action Required:
Under Regulation 10 (e) you are required to: Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.

Please state the actions you have taken or are planning to take:
No resident's charts are on display, publically. A cover was also put on all resident information clip boards.

Proposed Timescale: 13/06/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Balancing risk while ensuring privacy and dignity of residents required further review.

Action Required:
Under Regulation 10 (e) you are required to: Put in place adequate arrangements to ensure the operations of the designated centre are conducted with due regard to the sex, religious persuasion, racial origin, cultural and linguistic background, and any disability of residents.

Please state the actions you have taken or are planning to take:
The risk assessment will include a clear decision making process which outlines the inclusion of MDT, manager and resident/families. The hospital will develop a clear clinical governance policy outlining the roles and responsibilities for all aspects of clinical care.

Proposed Timescale: 13/06/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
When door wedges were removed, fire doors could not be maintained open and this greatly impeded residents freedom, especially those with assistive devices.

Action Required:

Under Regulation 10 (b) you are required to: Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

Please state the actions you have taken or are planning to take:
Resident/patient fire doors have an inbuilt door automatic closing mechanism. Other resident/patient room doors will have their door closing mechanism de-activated shortly. This approach will ensure risk will be balanced while upholding patient/resident privacy and dignity as well as facilitating their desire to allow a door to stay opened or closed.

Proposed Timescale: 13/06/2014

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Routine verification of references was not completed.

Action Required:
Under Regulation 18 (2) (c) you are required to: Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2.

Please state the actions you have taken or are planning to take:
The HR Department routinely writes and telephones the referee to ensure direct contact. When the HR Department writes, the referee is requested to authenticate by signature their name and role. This is completed three times for every employee.

Proposed Timescale: 13/06/2014